MEDICAL EXPENSE VERIFICATION

TO: (Name and address) DATE: _____
_____ TELEPHONE #: _____
_____ FAX #: _____
_____

APPLICANT/PARTICIPANT NAME: _____
SOCIAL SECURITY #: _____

FROM:

The individual named directly above is an applicant/tenant of the Federal Housing Tax Credit Program. Federal regulations require that we must verify income in order that the anticipated gross income for the next twelve months may be calculated. The information provided will remain confidential to satisfaction of that stated purpose only. Your prompt response is crucial and would be greatly appreciated.

Sincerely,_____
Project Owner/Management Agent

RETURN THIS FORM TO:

****

All medical expenses which are described below may be listed as allowances to help reduce my rental cost.

I hereby authorize release of any information requested regarding my income, assets, and allowances.

_____
Applicant/Resident Signature

TO BE COMPLETED BY THE HOSPITAL/CLINIC/PHARMACY/ETC. WHERE EXPENSES ARE INCURRED

SERVICES PROVIDED	MONTHLY COST	ANTICIPATED DURATION OF TREATMENT	YTD EXPENSES PAID BY PATIENT

Are any of these expenses paid by insurance? ☐ YES ☐ NO

Which Expenses? _____ Insurance Co.: _____

Does the applicant have outstanding bills that are still being paid? ☐ YES ☐ NO

If yes, payment per month is? _____

COMMENTS: _____

Signature of Person Verifying Information: _____ Telephone: _____

Title: _____ Date: _____